

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155352		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/04/2014	
NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00142771.</p> <p>Complaint IN00142771 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: February 4, 2014</p> <p>Facility number: 000243 Provider number: 155352 AIM number: 100289830</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 52 Total: 52</p> <p>Census payor type: Medicare: 6 Medicaid: 42 Other: 4 Total: 52</p> <p>Sample: 3</p> <p>Elkhart Rehabilitation Center was found to be in compliance in regards to the Investigation of Complaint IN00142771.</p> <p>Quality Review completed on February 5, 2014, by Brenda Meredith, R.N.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.